

APPENDIX G

DEFINITION OF TERMS

References

20 CFR Part 10. Federal Employees' Compensation Act.

20 CFR Part 701. Longshoremen's and Harbor Workers' Compensation Act and Related Statutes.

Definition of Terms

Benefits or Compensation (FECA) means the money paid or payable under the Act to the employee on account of loss of wages or loss of wage-earning capacity, and to enumerated survivors on account of the employee's death, and includes any other benefits paid for from the Employee's Compensation fund such as scheduled compensation under 5 U.S.C. 8107, medical diagnostic and treatment services supplied pursuant to the Act and this part, vocational rehabilitation services, additional money for services of an attendant or for vocational rehabilitation under 5 U.S.C. 8111, and funeral expenses under 5 U.S.C. 8134, but does not include continuation of pay as provided by 5 U.S.C. 8118.

Continuation of Pay (COP) (FECA) means continuation of an employee's regular salary for up to 45 calendar days of wage loss due to disability and/or medical treatment following a traumatic injury. The intent of this provision is to eliminate interruption of the employee's income while the Department of Labor's Office of Workers' Compensation Program (OWCP) is processing the claim. COP is not considered compensation and is therefore subject to deductions for income tax, retirement, etc.

Controvert (FECA) means to dispute, challenge, or deny the validity of a claim for workers' compensation and/or claim for COP. Unless the employing agency controverts the claim for one of the reasons listed below, the employee is entitled to COP for up to 45 calendar days of disability. The employing agency must continue the employee's pay unless the controversion is based on one of the nine reasons listed on the back of the Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (Form CA-1).

Disability (FECA) means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment; but such term shall mean permanent impairment, determined (to the extent covered thereby) under the

guides to the evaluation of permanent impairment promulgated and modified from time to time by the American Medical Association, in the case of an individual whose claim is described in section 910(d)(2) of this title (33 U.S.C.).

Impairment (FECA) means any anatomic or functional abnormality or loss. A permanent impairment is any such abnormality or loss after maximum medical improvement has been achieved.

Injury (FECA) means wound or condition of the body induced by accident or trauma, and includes a disease or illness proximately caused by the employment for which benefits are provided under the Act. The term "injury" includes damage to or destruction of medical braces, artificial limbs, and other prosthetic devices which shall be replaced or repaired; except that eyeglasses and hearing aids shall not be replaced, repaired, or otherwise compensated for, unless the damage or destruction is incident to a personal injury requiring medical services.

Injury (LHWCA) means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such an accidental injury and includes an injury caused by the willful act of a third person directed against an employee because of his employment.

Occupational disease or illness (FECA) means a condition produced in the work environment over a period longer than a single workday or shift by such factors as systemic infection; continued or repeated stress or strain; or exposure to hazardous elements such as, but not limited to, toxins, poisons, fumes, noise, particulates, or radiation, or other continued or repeated conditions or factors of the work environment.

The term **physician** (FECA) includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors within the scope of their practice as defined by State law. Under FECA, the services of chiropractors may be reimbursed only for treatment consisting of manual subluxation as demonstrated by X-ray to exist. The term "subluxation" is defined as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically which must be demonstrable on any X-ray film to individuals trained in the reading of X-rays.

Temporary aggravation (FECA) means that factors of employment have directly caused an underlying or pre-existing condition, disease or illness to be more severe for a definite limited period of time and thereafter leaves no greater impairment than existed prior to the

employment injury.

Traumatic injury (FECA) means a wound or other condition of the body caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected. The injury must be caused by a specific event or incident or series of events or incidents within a single work day or workshift.

SAMPLE PROTOCOL FOR INJURED WORKERS

- Injured worker reports to supervisor. (CA-1 initiated)
- Supervisor:
 1. Arranges appropriate transportation for employee i.e. ambulance, government vehicle or privately owned vehicle, to occupational health (OH) unit or medical treatment facility (MTF).
 2. Notifies Safety of injury. (Safety notifies ICPA)
- OH unit or MTF provides assessment, emergent care and documentation of injury including history of injury.
- OH or MTF offers treatment of injury.

If employee elects care from OH unit or MTF:

- * Care provided to the extent of the MTF capabilities; OH unit provides follow-up on referrals to other departments.
- * OH forwards copy of the Dispensary Permit to supervisor and Safety, and a copy of the pertinent entry on the SF600 to ICPA after each visit. Supervisor calls OH unit to clarify any questions.

If employee elects care from private physician:

- * OH unit calls private physician for appointment.
- * OH provides CA-17, command light duty packet and a copy of the initial assessment to private physician.
- * OH unit forwards copy of the Dispensary Permit to supervisor and Safety, and a copy of the pertinent entry on the SF600 to ICPA.

* Worksite visit by OH unit to determine appropriate work limitations.

* OH provides support to ICPA to clarify medical documentation received from the private physician.

* Employee reports to OH unit upon return to work. OH unit provides follow-up and clarification of limitations.

From: CHBUMED ltr 12000 Ser 3B421/0143 of 21 Jun 91. *Occupational Health Participation in Federal Employee Act (FECA) Cost Containment.*

**Federal Employee's Notice of
Traumatic Injury and Claim for
Continuation of Pay/Compensation**



Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data					
1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr. 		4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Home telephone ()	
6. Grade as of date of injury				Level Step	
7. Employee's home mailing address (Include city, state, and zip code)				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	

Description of Injury					
9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)					
10. Date injury occurred Mo. Day Yr. 		Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		11. Date of this notice Mo. Day Yr. 	
12. Employee's occupation					
13. Cause of injury (Describe what happened and why)					
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)					
				a. Occupation code	
				b. Type code	
				c. Source code	
				OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- ☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- ☐ b. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed
Address	City	State Zip Code

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

17. Agency name and address of reporting office (Include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
Zip Code	

18. Employee's duty station (Street address and zip code)	Zip Code
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19. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
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21. Date of injury Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	22. Date notice received Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	23. Date stopped work Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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24. Date pay stopped Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	25. Date 45 day period began Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	26. Date returned to work Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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27. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

29. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 31.)	30. Name and address of third party (Include city, state, and zip code) <hr/> <hr/>
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31. Name and address of physician first providing medical care (Include city, state, zip code) <hr/>	32. First date medical care received Mo. Yr. <input type="text"/> <input type="text"/>
	33. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

35. Does the employing agency controvert continuation of pay? <input type="checkbox"/> Yes (If "Yes," explain) <input type="checkbox"/> No (See instructions for explanation of "controvert")	36. Pay rate when employee stopped work \$ Per
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Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)	
Signature of supervisor	Date
Supervisor's Title	Office phone

38. Filing instructions ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

☐ No lost time, medical expense incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr. 	4. Sex 	5. Home telephone ()	6. Grade as of date of last exposure Level Step		
7. Employee's home mailing address (Include city, state, and zip code)				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	
Zip Code					

Claim Information

9. Employee's occupation	a. Occupation code
10. Location (address) where you worked when disease or illness occurred (Include city, state, and zip code)	11. Date you first became aware of disease or illness Mo. Day Yr.
12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr. 	13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness	OWCP Use - NOI Code	
	b. Type code	c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

Signature of employee or person acting on his/her behalf _____ Date _____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report	
19. Agency name, and address of reporting office (Include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
Zip Code	

20. Employee's duty station (Street address and zip code)	Zip Code
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21. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	22. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
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23. Name and address of physician first providing medical care (Include city, state, zip code)	24. First date medical care received Mo. Day Yr. <div style="border-bottom: 1px solid black; width: 100%;"></div>
	25. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

26. Date employee first reported condition to supervisor Mo. Day Yr. <div style="border-bottom: 1px solid black; width: 100%;"></div>	27. Date and hour employee stopped work Mo. Day Yr. Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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28. Date and hour employee's pay stopped Mo. Day Yr. Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr. <div style="border-bottom: 1px solid black; width: 100%;"></div>
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30. Date returned to work Mo. Day Yr. Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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31. If employee has returned to work and work assignment has changed, describe new duties

32. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," go to item 34.	33. Name and address of third party (Include city, state, and zip code) <div style="border-bottom: 1px solid black; height: 20px;"></div> <div style="border-bottom: 1px solid black; height: 20px;"></div>
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Signature of Supervisor

34. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor

Date

Supervisor's Title

Office phone

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

LONGSHOREMEN'S AND HARBOR
WORKERS' COMPENSATION ACT

**EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL ILLNESS**

(See instructions on reverse - Leave items 1 and 2 blank)

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL ILLNESS (See instructions on reverse - Leave items 1 and 2 blank)		1. OWCP No.	
		2. Carrier's No.	
		3. Date and time of accident Mo. Day Yr. Hour AM PM	
4. Name of injured/deceased employee (Type or print - first, M.I., last) Telephone:		5. Employee's address (No., St., City, State, ZIP code)	
6. Injury is reported under the following act (Mark one) A <input type="checkbox"/> Longshoremen's and Harbor Workers' Compensation Act B <input type="checkbox"/> Defense Base Act C <input type="checkbox"/> Nonappropriated Fund Instrumentalities Act D <input type="checkbox"/> Outer Continental Shelf Lands Act E <input type="checkbox"/> District of Columbia Compensation Act	7. Indicate where injury occurred (Longshore Act only) (Mark one) A <input type="checkbox"/> Aboard vessel or over navigable waters B <input type="checkbox"/> Pier/Wharf C <input type="checkbox"/> Dry dock D <input type="checkbox"/> Marine terminal E <input type="checkbox"/> Building way F <input type="checkbox"/> Marine railway G <input type="checkbox"/> Other adjoining area	8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Age or date of birth
		10. Social Security No. (See statement on reverse)	
		11. Did injury cause death? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, skip to 16	
		12. Did injury cause loss of time beyond day or shift of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Did employee stop work immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Date and Hour employee returned to work	
17. Did injury/death occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Dept. in which employee normally works(ed)	
19. Occupation		20. Date and Hour pay stopped	
21. Which days usually worked per week? (Mark (X) days) S M T W T F S		22. Date employer or foreman first knew of accident	
23. Wages or earnings (Include overtime, allowances, etc.)		24. Exact place where accident occurred (See instructions on reverse). This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.	
a. Hourly \$ b. Daily \$ c. Weekly \$ d. Yearly \$		25. How was knowledge of accident or occupational illness gained?	
26. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.) <div style="text-align: right;">(Use additional sheet(s) if required and attach to this report)</div>			
27. NATURE OF INJURY (Name part of body affected - fractured left leg, bruised right thumb, etc.) If there was amputation of a member of the body, describe.			
28. Has medical attention been authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Enter date of authorization	30. Was first treating physician chosen by employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Has insurance carrier been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME		ADDRESS - Enter number, St., City, State, ZIP code	
32. Physician			
33. Hospital			
34. Insurance carrier			
35. Employer			
36. Nature of employer's business		37. Signature of person authorized to sign for employer	
38. Official title of person signing this report		39. Date of this report	

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

NOTICE OF EMPLOYEE'S INJURY OR DEATH
Longshoremen's and Harbor Workers' Compensation Act, as extended
(See instructions on reverse)

1. Employee's name (Last, first, middle)		2. Home mailing address (Number, street, city, state, ZIP code)	
3. Date of birth (Month, day, year)	4. <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Social security number (voluntary)	6. Home telephone Area code : Number
7. Name and address of employer (Number, street, city, state, ZIP code)			8. Employee's job title
9. Date of injury (Month, day, year)	10. Hour of injury <input type="checkbox"/> AM <input type="checkbox"/> PM	11. Place where injury occurred	
12. Name of supervisor at time of injury		13. Did employee stop work due to injury?	14. If yes, date stopped
15. Cause of injury (Explain in what way the injury or occupational illness was caused by employment)			
16. Effects of injury (Indicate parts of body affected or if death occurred)-			
<p>NOTE: If reporting injury, employee signs item 17; if reporting death, claimant or representative signs item 18</p>			
<p>17. I am requesting the employer named in item 7 to provide me appropriate compensation and medical care for my injury, and I hereby make claim for all benefits to which I may be entitled under the Longshoremen's and Harbor Workers' Compensation Act, or a related law.</p> <p>_____ Signature of Employee</p> <p>_____ Date</p>			
<p>18. Request is hereby made to the employer named in item 7 to provide appropriate death benefits to the survivors of the employee named in item 1, and a claim is hereby made for those death benefits to which these survivors may be entitled under the Longshoremen's and Harbor Workers' Compensation Act, or a related law.</p> <p>_____ Signature of Compensation Claimant or Representative of Claimant</p> <p>_____ Date</p>			
<p>19. This notice is being personally delivered, or mailed, to the employer named in item 7 (or his representative) and a copy is being sent to the Deputy Commissioner of the Office of Workers' Compensation Programs by the party named in either item 17 or 18 on this date.</p> <p>_____ Date</p>			

This form should be furnished by the employer to any employee covered by the Longshoremen's Act or a related law who reports an occupational injury or illness to his/her employer.